Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(800) 633-2322 (916) 263-2382 FAX (916) 263-2487
www.mbc.ca.gov

INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE *OR* POSTGRADUATE TRAINING AUTHORIZATION LETTER

Application for (please check one): ☑ **License** ☐ **PTAL** - or - ☐ **Update**

1. NAME : Last	First	Middle	MBC Use Only
Wright	David	Craig	

Other names you have used (include maiden name):	2. U.S. Social Security Number
	[redacted]
3. Place of Birth	**4. Date of Birth**
[redacted]	[redacted]

5. Gender: ☑ Male ☐ Female

6. Public/Mailing Address: 141 Pacific Avenue
(Please note: this information is public)
(30 characters maximum per line, including spaces) _____

City	State/Province	Zip/Postal Code	Country
Pacific Grove	California	93950	usa

7. Telephone Numbers: (Include area code)	Home	Work	Cell
	[redacted]	[redacted]	[redacted]

8. California Driver's License Number (optional):	10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California?
[redacted]	☐ Yes ☑ No
9. E-mail Address (optional): [redacted]	Previous license number, if any: _____

Personal Data ☑

MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

School Name	City, State/Province, Country	Dates of Attendance
University of Virginia Medical School	Charlottesville, Virginia	1972 to 1976
		Sept 6, 1972 to May 16, 1976

12 Transcript ☑ ☑ ☐ ☐ ☐ ☐

12. School of Graduation	Degree Awarded	Date of Graduation
Medical School	MD	05-16-1976

Diploma ☑

EXAMINATIONS

13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or QME in Canada

Examination	Date	Result (Pass/Fail)
NBME	July 1,1977	[redacted]
American Board of Internal Medicine	September 15, 1982	
ABIM Subspecialty Infectious Disease	November 11, 1986	

Exams ☑ ☑ ☑

6009 5-5 1348 SM
Cashiering Use Only

VA 001
School Code

L1A

07A-100 (Rev. 04/2008)

240704

A "yes" response to Questions 14 through 38 requires a written explanation on a separate sheet of paper along with any supporting materials.

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

MBC Use Only

14. **Please list each ACGME/RCPSC accredited postgraduate training program in which you have participated. You must include each internship, residency and fellowship, whether or not the program was completed or credit granted.**

Postgraduate Training

Facility Name	Address	Specialty Area	Dates of Attendance
Harlem Hospital Center (Columbia P&S)	New York City, New York	Internal Medicine Internship	July 1,1976 to June 30, 1977
Walter Reed Army Medical Center	Washington, DC	Internal Medicine Residency	August 1, 1980 to July 31, 1982
Walter Reed Army Medical Center	Washington, DC	Infectious Disease Fellowship	August 1, 1982 to July 31, 1985

POSTGRADUATE TRAINING: (These questions are to be answered by ALL applicants)

Did you ever take a leave of absence or break from your training?	YES	NO
Have you ever been terminated, dismissed or expelled from a program?	YES	NO
Have you ever resigned from a training program?	YES	NO
Were you ever placed on probation?	YES	NO
Were you ever disciplined or placed under investigation?	YES	NO
Were any incident reports ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason?	YES	NO
Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	YES	NO

MEDICAL LICENSURE

15. **Please list all medical licenses (other than training licenses) that have ever been issued by any state or territory in the United States or Canadian province.**

License Data

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction

APPLICANT: David Craig Wright

DATE OF BIRTH: [redacted]

L1B

ABMS CERTIFICATIONS

MBC Use Only

ABMS

16. Are you currently certified by a Member Board of the American Board of Medical Specialties? YES ☑ NO ☐

Member Board	Expiration Date	Certificate Number
Internal Medicine	NA	87376
Infectious Disease	NA	87376

MALPRACTICE HISTORY

Malpractice

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of $30,000 or more? YES [redacted] NO [redacted]

PRACTICE IMPAIRMENT OR LIMITATIONS

Limitations

18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program? YES [redacted] NO [redacted]

19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? YES [redacted] NO [redacted]

20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? YES [redacted] NO [redacted]

21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? YES [redacted] NO [redacted]

22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? YES [redacted] NO [redacted]

If you do receive ongoing treatment or participate in a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

CRIMINAL RECORD HISTORY

Criminal Record

23. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in any state in the United States or foreign country?

This includes a citation, infraction, misdemeanor and/or felony, etc. If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.

For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a descriptive explanation of the circumstances surrounding the conviction or disciplinary action (i.e., dates and location of incident and all circumstances surrounding the incident). This letter must accompany the application. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.

Applicants who answer "NO" to the question but have a previous conviction or plea, may have their application denied or license revoked for knowingly falsifying the application. YES [redacted] NO [redacted]

APPLICANT: David Craig Wright

DATE OF BIRTH: [redacted]

L1C

CRIMINAL RECORD HISTORY (cont'd)

MBC Use Only
Criminal Record

24. Is any criminal action pending against you? YES [redacted] NO [redacted]

25. Are you required to register as a Sex Offender? YES [redacted] NO [redacted]

DISCIPLINARY HISTORY

Discipline

These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country.

26. Have you ever been denied a license to practice medicine? YES [redacted] NO [redacted]

27. Is any denial pending against you? YES [redacted] NO [redacted]

28. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital? YES [redacted] NO [redacted]

29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation? YES [redacted] NO [redacted]

30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation? YES [redacted] NO [redacted]

31. Have you ever had any license to practice medicine subjected to any other disciplinary action? YES [redacted] NO [redacted]

32. Is any disciplinary action pending against any of your licenses to practice medicine? YES [redacted] NO [redacted]

33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed? YES [redacted] NO [redacted]

34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action? YES [redacted] NO [redacted]

35. Is any disciplinary action pending against your hospital staff privileges? YES [redacted] NO [redacted]

36. Have you ever surrendered a license to practice medicine? YES [redacted] NO [redacted]

37. Have your DEA privileges ever been denied, suspended, restricted, or terminated? YES [redacted] NO [redacted]

38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA? YES [redacted] NO [redacted]

[redacted]

Notice: All items in this application, except #8 and #9, are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

The applicant, David Craig Wright (PLEASE PRINT FULL NAME), [redacted] (DATE OF BIRTH) being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE. DCW **(PLEASE INITIAL BOX)**

OK

SIGNATURE OF APPLICANT: David Craig Wright (Please sign full name)

State of California

County of Monterey

Subscribed and sworn to (or affirmed) before me on this 30TH day of APRIL, 2009,

by: (applicant's name to be printed here) DAVID CRAIG WRIGHT

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

SEE ATTACHMENT

SIGNATURE OF NOTARY PUBLIC

L1E

CTA-100 (Rev. 11/04/08)

Consumer Affairs

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CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

This certifies that David Craig Wright [redacted]
Full Name of Applicant — U.S. Social Security Number

[redacted] enrolled in University of Virginia
Date of Birth — Name of Medical School

located in Charlottesville, Virginia / USA on 09/06/1972.
State/Province Country — Enrollment Date

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 years of resident instruction, completing at least 4,000 hours, of which at least 80 percent actual attendance is required in the subjects set forth hereunder (Business and Professions Code Sections 2089,2089.5, 2089.7,2090, 2091.1,2091.2) and that the applicant

Anatomy	Embryology	Physical Medicine
Otolaryngology	Histology	Therapeutics
Obstetrics and Gynecology	Human Sexuality	Neuroanatomy
Radiology, including Radiation Safety	Medicine	Child Abuse Detection and Treatment
Tropical Medicine	Surgery, including Orthopedic Surgery	Geriatric Medicine
Physiology	Urology	Pediatrics
Biochemistry	Psychiatry	Pharmacology
Pathology, Bacteriology, and Immunology	Neurology	Anesthesia
Ophthalmology	Alcoholism and Chemical Dependency	Spousal Partner Abuse Detection & Treatment*
Dermatology	Preventative Medicine, including Nutrition	Family Medicine**
		Pain Management and End-of-Life-Care***

* ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.
** ONLY applicable to medical students who graduate from medical school on or after May 1, 1998.
*** ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000.

☑ **was granted the degree of Bachelor/Doctor of Medicine on the** 16TH **day of** MAY, 1976.

☐ **withdrew from medical school on** ____ **day of** _____, _____.

Unusual Circumstances

	Responses	
Did this individual ever take a leave of absence from their medical education?	Yes [redacted]	No [redacted]
Was this individual ever placed on probation?	Yes [redacted]	No [redacted]
Was this individual ever disciplined or under investigation?	Yes [redacted]	No [redacted]
Were any incident reports regarding this individual ever filed by instructors?	Yes [redacted]	No [redacted]
Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason?	Yes [redacted]	No [redacted]

A "Yes" response to ANY of the above questions requires the medical school to provide a written explanation on a separate attachment.

Medical School Seal Must Be Imprinted Below	Attention Medical School: Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.
	Signed and the school seal affixed this 5TH day of MAY, 2009.
	By: Alane Celli, Credentialing Officer Printed Name and Title of School Official
	Signature: Alane Celli

L2

5-5

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor

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2009 JUN 12 AM 9:35
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Consumer Affairs

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2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(800) 633-2322 (916) 263-2382 FAX (916) 263-2487
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CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

PART 1: TO BE COMPLETED BY THE APPLICANT

NAME: Last Wright First David Middle Craig

U.S. Social Security Number [redacted] Date of Birth [redacted] Telephone Number Home [redacted] Work [redacted]

Public/Mailing Address 141 Pacific Avenue

City Pacific Grove State/Province CA Zip/Postal Code 93950

Medical School of Graduation: Univ. of Virginia Med. Sch 5/16/76

PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility: **Harlem Hospital Center**
Department of Medicine, Rm #14101 MLK

ACGME 10 digit Program number: (www.acgme.org) 1403511273

Address of Facility: ~~506 Lenox Avenue~~
New York, NY 10037

Telephone #: [redacted]

Categorical Specialty Area of Training: IM

Start Date of Training: 07,01,1976

End Date (or anticipated completion date) of Training: 06,30,1977

OK

UNUSUAL CIRCUMSTANCES:

Did the trainee ever take a leave of absence or break from their training?	YES [redacted]	NO [redacted]
Was the trainee ever terminated, dismissed or expelled?	YES [redacted]	NO [redacted]
Did the trainee ever resign?	YES [redacted]	NO [redacted]
Was the trainee ever placed on probation?	YES [redacted]	NO [redacted]
Was the trainee ever disciplined or placed under investigation?	YES [redacted]	NO [redacted]
Were any incident reports regarding this trainee ever filed by instructors?	YES [redacted]	NO [redacted]
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES [redacted]	NO [redacted]
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES [redacted]	NO [redacted]

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

L3A

DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILTY FOR PATIENT CARE.

GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete **at least four months** of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to licensure. The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months.

I hereby certify as the program director, that the individual named in Part 1

☐ **has completed** ☐ **has not completed**

a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.

Jmica Capps

SIGNATURE OF PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL	OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

The training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant, and the applicant was trained in an accredited ACGME or RCPSC program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

Linnea Capps, MD
Residency Program Director, Department of Medicine

PRINT NAME OF PROGRAM DIRECTOR

Jmica Capps

SIGNATURE OF PROGRAM DIRECTOR
Signature Stamp Is Not Acceptable

6/2/09

DATE SIGNED

OK

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of NY

County of NY

Subscribed and sworn to (or affirmed) before me on

this 3rd day of June, 20 09.

by Linnea Capps

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

Roberta Bart Cheryl
Notary Public, State of New York
No. 01R06095315
Qualified in New York County
Expiration July 7, 20 11

SIGNATURE OF NOTARY PUBLIC

L3B

07A-100-L3 (Rev. 12/05)

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

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CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

PART 1: TO BE COMPLETED BY THE APPLICANT

NAME: Last	First	Middle
Wright	David	Craig

U.S. Social Security Number	Date of Birth	Telephone Number
[redacted]	[redacted]	Home [redacted] Work [redacted]

Public/Mailing Address: 141 Pacific Avenue

City	State/Province	Zip/Postal Code
Pacific Grove	California	93950

Medical School of Graduation: University of Virginia May 16, 1976
Medical School: Medical School

PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR

ATTENTION: PROGRAM DIRECTOR: [illegible] the last day of any postgraduate training year [illegible] by the applicant to satisfy the requirements of this form and certify that the individual named in PART 1 above has satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has met the skill and specific clinical competency requirements for unrestricted practice of medicine in this field.

Name of Facility: ACGME 10 digit Program number: (www.acgme.org)

Address of Facility: Telephone #:

Categorical Specialty Area of Training	Start Date of Training	End Date (or anticipated completion date) of Training
	__/__/____	__/__/____

UNUSUAL CIRCUMSTANCES:

Did the trainee ever take a leave of absence or break from their training?	YES [redacted]	NO [redacted]
Was the trainee ever terminated, dismissed or expelled?	YES [redacted]	NO [redacted]
Did the trainee ever resign?	YES [redacted]	NO [redacted]
Was the trainee ever placed on probation?	YES [redacted]	NO [redacted]
Was the trainee ever disciplined or placed under investigation?	YES [redacted]	NO [redacted]
Were any incident reports regarding this trainee ever filed by instructors?	YES [redacted]	NO [redacted]
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES [redacted]	NO [redacted]
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES [redacted]	NO [redacted]

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

L3A

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**88577**
File Number:	**226886**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14597676**
Application Date:	**02/12/2019 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military?	**Yes**

Personal Detail

First Name:	**DAVID**
Middle Name:	**CRAIG**
Last Name:	**WRIGHT**
Birthdate:	****/**/******
Gender:	**Male**

Addresses

License Related Addresses

Address of Record (Required)

Warning: **In order to protect your privacy and identity, address will not be displayed.**

License Attributes Selected

Secondary Status	**Military**

Questions

Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country?	[redacted]
Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver?	[redacted]

I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose. [redacted]

Family Physician Training Program Voluntary Fee

Would you like to contribute? [redacted]

Amount:

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Patient Care - 40+ Hours**
	Research - 10-19 Hours
Patient Care Practice Location	**Zip: 93950 County: MONTEREY**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Areas of Practice	**Infectious Disease - Secondary**
	Internal Medicine - Primary
Board Certifications	**American Board of Internal Medicine - Infectious Disease**
	American Board of Internal Medicine - Internal Medicine
Postgraduate Training Years	**6 Years**
Cultural Background	**White**
Web Site Profile	**Cultural Background - Yes**
	Foreign Language Proficiency - Yes
	Gender - Yes
E-mail:	[redacted]

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**
StephenM.ThompsonLRP	**$25.00**
Vol.Funds	**$25.00**
Total Amount Due:	**$845.00**

Applications are not considered submitted for processing until payment is received.

Attestation

I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations provided, including supplementary attached hereto, are true, complete and accurate.

Signature: Date:

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**88577**
File Number:	**226886**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14367706**
Application Date:	**03/27/2017 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military? [redacted]

Personal Detail

First Name:	**DAVID**
Middle Name:	**CRAIG**
Last Name:	**WRIGHT**
Birthdate:	****/**/******
Gender:	**Male**

Addresses

License Related Addresses

Address of Record (Required)

Warning: **In order to protect your privacy and identity, address will not be displayed.**

Questions

Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country? [redacted]

Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver? [redacted]

I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose. [redacted]

Family Physician Training Program Voluntary Fee

Voluntary Fee: [redacted]

Amount - $25.00 Minimum:

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 10-19 Hours**
	Other - None
	Patient Care - 40+ Hours
	Research - 1-9 Hours
	Teaching - None
	Telemedicine - None
Patient Care Practice Location	**Zip: 93950 County: MONTEREY**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Infectious Disease - Primary**
	Internal Medicine - Secondary
Board Certifications	**American Board of Internal Medicine - Infectious Disease**
	American Board of Internal Medicine - Internal Medicine
Postgraduate Training Years	**6 Years**
Cultural Background	**European**
Web Site Profile	**Cultural Background - Yes**
	Foreign Language Proficiency - Yes
	Gender - Yes
E-mail:	[redacted]

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Family Physician Training Fee	**$25.00**
Total Amount Due:	**$845.00**

Applications are not considered submitted for processing until payment is received.

Attestation

I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations provided, including supplementary attached hereto, are true, complete and accurate.

Signature: Date:

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**88577**
File Number:	**226886**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14148505**
Application Date:	**02/05/2015 (mm/dd/yyyy)**

Personal Detail

First Name:	**DAVID**
Middle Name:	**CRAIG**
Last Name:	**WRIGHT**
Birthdate:	****/**/******
Gender:	**Male**

Addresses

License Related Addresses

Address of Record (Required)

Warning: **In order to protect your privacy and identity, address will not be displayed.**

Questions

Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country?	[redacted]
Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver?	[redacted]
I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose.	[redacted]

Family Physician Training Program Voluntary Fee

Voluntary Fee: [redacted]

14231825 16318

Amount - $25.00 Minimum: [redacted]

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 10-19 Hours**
	Other - None
	Patient Care - 40+ Hours
	Research - 1-9 Hours
	Teaching - None
Patient Care Practice Location	**Zip: 93940 County: MONTEREY**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Infectious Disease - Primary**
	Internal Medicine - Secondary
Board Certifications	**American Board of Internal Medicine - Infectious Disease**
	American Board of Internal Medicine - Internal Medicine
Postgraduate Training Years	**6 Years**
Cultural Background	**European**
Foreign Language Proficiency	[redacted]
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - No
	Gender - Yes
E-mail:	[redacted]

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Family Physician Training Fee	**$25.00**

Total Amount Due: **$845.00**

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Signature: Date: